Dr. BALLIN
Within corporate limits

08033

08036

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08036

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS SACRED HEART HOSPITAL 20

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W. VA. COUNTY MINERAL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley 85x-9
STREET ADDRESS (If rural give location) 5 Potomac Ave.

3. NAME OF DECEASED: (Type or Print) (First) FRANCES (Middle) Cemeda (Last) BAKER

4. DATE OF DEATH: (Month) 9 (Day) 22 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: JUNE 3, 1896
9. AGE last birthday 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: Dry Cleaning
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Deceased~~ Sherman Castle
14. MOTHER'S MAIDEN NAME: ~~Deceased~~ Sarah ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-24-8508
17. INFORMANT & ADDRESS: Mr. Leo Baker Ridgely, W. Va.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerotic Heart Disease — 4 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1949 to Sept 22, 1954, that I last saw the deceased alive on 22 Sept, 1954, and that death occurred at 4:00 p M, from the causes and on the date stated above.

SIGNATURE Ralph L. Ballin M. D. ADDRESS 62 Greene St Cumberland DATE SIGNED Sept 22, 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: 9/25/54
NAME OF CEMETERY OR CREMATORY: Zion Memorial Cem.
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Sept. 25, 1954
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

RECEIVED
SEP 28 1954
BUREAU V. S.

08092

08037

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 1

1. PLACE OF DEATH:

COUNTY Allegany | MARYLAND

CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Near Bloomington | LENGTH OF STAY (In this place) X

HOSPITAL OR INSTITUTION OR STREET ADDRESS In car, off route 51 a short distance west of nine mile house.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland

STREET ADDRESS (If rural, give location) 601 Bedford St.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Marie	Louise	Beeche	Sept.	about 17	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	white	married	June 14-1912	42 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Clerk For	City Water Dept.	Cumberland, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William C. Zilch	Louise Armbuster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		(husband) Walter T. Beeche, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Asphyxia due to	
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Carbon monoxide poisoning.	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Despondent & nervousness

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or Town)	(County)	(State)
	Route 51	near Cumberland	Allegany	Md.

21d. TIME (Month) OF INJURY	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED While at work ☐	Not while at work ☒	21f. HOW DID INJURY OCCUR?
about Sept.	17	54	P.M.			Hose attached to exhaust pipe, then through right rear vent window of car.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Sept. 20-1954

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 22, 1954	Hillcrest Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 22, 1954	Mo Day Duckworth	Louis Stein, Inc.,	"

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

RECEIVED
SEP 27 1954
BUREAU V. S.

08093

08038

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Nikep (near Lonaconing)

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MD. COUNTY: ALLEGANY

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Moscow

STREET ADDRESS (If rural, give location): - -

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles J Beeman	Sept 12 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Single	Dec. 21, 1902	51 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Miner	Coal Mine	Moscow, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Charles Beeman	Marion Nicols

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	220-10-2297	Mrs. Silas Shriver, Moscow, Md. (SISTER)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Injuries rcvd. when struck by car	instantaneous
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
	Rt 36	Nikep Alleg Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
9/10/54 12 A M.		Struck by automobile

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: R. H. Williams — Acting CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ M. D. — DATE SIGNED: 9/12/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept. 14, 1954	Laurel Hill Cemetery	Moscow, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-13-54	Jeanette M. Boal	George Eichhorn, Lonaconing, MD.	

VS. A15A - 5 - 53

RECEIVED
SEP 17 1954
BUREAU V. E.

Within corporate limits DR. SIMONS

03037

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08039

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND
LENGTH OF STAY (in this place) 48 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near CUMBERLAND, rural
STREET ADDRESS (If rural give location) RT. #4 Christie Road

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) BELLE (Last) BRAMBLE

4. DATE OF DEATH: (Month) SEPT. (Day) 20 (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: APRIL 10, 1941
9. AGE last birthday 13 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U.SA

13. FATHER'S NAME: ARTHUR BRAMBLE
14. MOTHER'S MAIDEN NAME: EMMA ARNOLD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Memorial Hosp. - Cumb. Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

401.3

IMMEDIATE CAUSE (A) R heumatic cardites — INTERVAL BETWEEN ONSET AND DEATH: 48 days

ANTECEDENT CAUSE (S) DUE TO (B) R heumatic fever — 4 months

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3, 1954, to 9/20, 1954, that I last saw the deceased alive on 9/20, 1954, and that death occurred at 8:54AM, from the causes and on the date stated above.

SIGNATURE George M Simons M.D. ADDRESS Cumberland Md DATE SIGNED 9/21/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF 9-22-54
NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 22, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George - ADDRESS Cumb. Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 -

RECEIVED
SEP 28 1954
BUREAU V. S.

Corporate Limits

DR. R. J. W...

05033

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08040

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE W. VA. COUNTY Mineral
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY, W. VA.
STREET ADDRESS (If rural give location) RT. #1

3. NAME OF DECEASED: (Type or Print) (First) THEODORE (Middle) (Last) BURLEY

4. DATE OF DEATH: (Month) SEPT. (Day) 13 (Year) 1954

5. SEX: MALE
6. COLOR OR RACE: COLORED
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH: Jan. 4, 1894
9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY: B & O Laborer Railroad
11. BIRTHPLACE (State or foreign country): W. VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: BURLEY, PARIS
14. MOTHER'S MAIDEN NAME: Ruth Ellen Pope.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-05-5347
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331K

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Uremia

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 9/11/54, 19..., to 9/13/54, 19..., that I last saw the deceased alive on 9/13/54, 19..., and that death occurred at 10:05 P.M. from the causes and on the date stated above.

SIGNATURE [signature] M.D. ADDRESS Cumberland DATE SIGNED 9/14/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Sept 16 1954
NAME OF CEMETERY OR CREMATORY Pope Cem.
LOCATION (City, town, or county) Ridgley W Va. (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 14, 1954
REGISTRAR'S SIGNATURE Walter R. Manz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumb. Md

VS. A15—10-...

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 21 1954
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08039 **CERTIFICATE OF DEATH** 08041

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 8 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVENUE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 214 COLUMBIA STREET

3. NAME OF DECEASED: (Type or Print) (First) GLEN (Middle) R. (Last) CHAPPELL

4. DATE OF DEATH (Month) 9 (Day) 19 (Year) 19 54

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: AUGUST 23 1908

9. AGE last birthday 46 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10B. KIND OF BUSINESS OR INDUSTRY: Sloan Loan Co

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT CHAPPELL

14. MOTHER'S MAIDEN NAME: LILLIAN RAFTERM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-5049

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.

IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 8 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Essential Hypertension

(C) Chronic Nephritis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-24, 1953 to 9-19, 1954 that I last saw the deceased alive on 9-19-1954, and that death occurred at 9:35 P.M., from the causes and on the date stated above.

SIGNATURE W. J. Williams M.D. ADDRESS Cumberland DATE SIGNED 9-21-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept 22 1954

NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park

LOCATION (City, town, or county) (State) Cumberland Md

DATE REC'D BY LOCAL REGISTRAR Sept 22, 1954

REGISTRAR'S SIGNATURE Walter R. Krantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-5

RECEIVED
SEP 28 1934
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08042

08040 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 7/13/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 508 Columbia Avenue

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) B. (Last) Clark

4. DATE OF DEATH (Month) (Day) (Year) September 19, 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widower

8. DATE OF BIRTH: May 8, 1881

9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired- --

10B. KIND OF BUSINESS OR INDUSTRY: Bar Tender

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Edward Clark

14. MOTHER'S MAIDEN NAME: Emma Rossworm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary Hypostasis — INTERVAL BETWEEN ONSET AND DEATH 48 hrs

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Cerebral arteriosclerosis — ?

(C) DUE TO Chronic myocarditis — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension — ?

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 13, 1954 to Sept. 19, 1954 that I last saw the deceased alive on Sept. 18, 1954, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

SIGNATURE James E. McLean M.D. ADDRESS 49 Greene St. DATE SIGNED 9-20-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept 22 1954

NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 21, 1954

REGISTRAR'S SIGNATURE Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland Md.

SEP
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08043

08094

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing
LENGTH OF STAY (in this place) 63
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing
STREET ADDRESS (If rural give location) WAshington Street

3. NAME OF DECEASED: (Type or Print) (First) Margery (Middle) C (Last) Connor

4. DATE OF DEATH: (Month) Sept. (Day) 2 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May 19 1891
9. AGE last birthday 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Lonaconing, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James I Ternent
14. MOTHER'S MAIDEN NAME: Margaret Carthew

15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Mrs. Harold Connor, Lonaconing, md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A)	Coronary Occlusion	8 hours
ANTECEDENT CAUSE (S)	DUE TO (B)	Arteriosclerotic Heart Disease	2 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C)	Diabetes Mellitus	15 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1952, to 2 Sept., 1954, that I last saw the deceased alive on 2 Sept., 1954, and that death occurred at 9 45 AM, from the causes and on the date stated above.

SIGNATURE George Richards Jr. MD
ADDRESS M.D. Lonaconing, Md.
DATE SIGNED 9-2-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept. 5. 1954
NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
LOCATION (City, town, or county) (State): Lonaconing, Md.

DATE REC'D BY LOCAL REGISTRAR: 9-4-54
REGISTRAR'S SIGNATURE: Jannette M Boal
24. FUNERAL DIRECTOR: George Eichhorn, Lonaconing, Md.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-

SEP 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08044

DR. TOPPER 08041 CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-5

1. PLACE OF DEATH: COUNTY ALLEGANY; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND; MARYLAND; LENGTH OF STAY (in this place) 7 HOURS; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MT. SAVAGE; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) JAMES (Middle) E Ellsworth (Last) CRUMP

4. DATE OF DEATH: (Month) SEPT. (Day) 10, (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH: OCTOBER 15, 1895

9. AGE last birthday 59 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Line Supervisor

10B. KIND OF BUSINESS OR INDUSTRY: BALLISTICS

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE CRUMP

14. MOTHER'S MAIDEN NAME: MARGARET BRODE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W. I

16. SOCIAL SECURITY NO. 214-05-6045

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Chronic Coronary Artery Disease — 3 yrs

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1 —, 1954, to Sep 10, 1954, that I last saw the deceased alive on Sep 10, 1954, and that death occurred at 4:00 AM, from the causes and on the date stated above.

SIGNATURE John A. Topper M. D. ADDRESS Hyndman Pa DATE SIGNED 9/10/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: Sept 12-54 — NAME OF CEMETERY OR CREMATORY: St. George's — LOCATION (City, town, or county) (State): Mt Savage Md

DATE REC'D BY LOCAL REGISTRAR: Sept. 12, 1954 — REGISTRAR'S SIGNATURE: Wenter L. Frantz, M.D.

24. FUNERAL DIRECTOR: J. R. Durst — ADDRESS: Frostburg Md

RECEIVED
SEP 21 19 4
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08045

08042

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY: Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland

LENGTH OF STAY (in this place): 83 Years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 429. Fayette St

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland

STREET ADDRESS (If rural give location): 429. Fayette St

3. NAME OF DECEASED: (Type or Print) (First) Bertha (Middle) (Last) Dailey

4. DATE OF DEATH: (Month) Sept (Day) 8 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: March 17 1871

9. AGE last birthday: 83 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own House

11. BIRTHPLACE (State or foreign country): Cumberland, Allegany Co, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. Kuhn

14. MOTHER'S MAIDEN NAME: Catherine Bill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Joseph L. Read, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) DUE TO: Cerebral Arterial Occlusion

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) DUE TO: Arteriosclerosis, generalized

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/8 ,1954, to 9/8 ,1954, that I last saw the deceased alive on 9/8 ,1954, and that death occurred at 11:40 PM from the causes and on the date stated above.

SIGNATURE: Leo N. Ley Jr. (Degree or title) M.D. — ADDRESS: 452 N. Centre St. — DATE SIGNED: 9/10/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept 11 1954 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — LOCATION (City, town, or county) (State): Cumberland Md

DATE RECD BY LOCAL REGISTRAR: Sept. 11, 1954 — REGISTRAR'S SIGNATURE: Walter K. Hauch, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

DR ...FAW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08043

08046

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH.
COUNTY ALLEGANY — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,
LENGTH OF STAY (in this place) 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE PENNA COUNTY Bedford
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEDFORD, Rural
STREET ADDRESS (If rural give location) Bedford RR4

3. NAME OF DECEASED: (Type or Print) (First) H. (Middle) RAY (Last) DIEHL

4. DATE OF DEATH: (Month) SEPT. (Day) 2 (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED

8. DATE OF BIRTH. FEB. 1 1905

9. AGE last birthday 49 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER

10B. KIND OF BUSINESS OR INDUSTRY K-WOOD C. LUMBER WORKING PLANT

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LLOYD DIEHL

14. MOTHER'S MAIDEN NAME: ELLA STAYER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Memorial Hosp. Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) DUE TO: Coronary Heart Disease — 1 hour

ANTECEDENT CAUSE (B) DUE TO:

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypostasis mod. severe — 1 year +

19A. DATE OF OPERATION: Sep 2 1954

19B. MAJOR FINDINGS OF OPERATION - Toxic thyroid enlargement - Reacted from anesthesia - appx 2 hours before Heart attack

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 26 Aug, 1954, to 2 Sep, 1954, that I last saw the deceased alive on 2 Sep, 1954 and that death occurred at 1:15PM, from the causes and on the date stated above.

SIGNATURE W M Faw Jr. M. D. ADDRESS Cumberland Md DATE SIGNED 2 Sep 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Sept. 5, 1954 — NAME OF CEMETERY OR CREMATORY Bedford Cem — LOCATION (City, town, or county) (State) Bedford, Pa

DATE REC'D BY LOCAL REGISTRAR Sept. 3, 1954 — REGISTRAR'S SIGNATURE Hunter K. Hartz, M.D. — 24. FUNERAL DIRECTOR John J. Hafer — ADDRESS Cumberland, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 8

08095

08047
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 309 S. Ceder Street
LENGTH OF STAY (in this place) 33 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 309 S. Ceder Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 309 S. Ceder Street

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) Fillmore (Last) Dyer
4. DATE OF DEATH (Month) 9 (Day) 5 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: May 12, 1899
9. AGE last birthday: 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Blacksmith
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Patterson Creek, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elliott B. Dyer
14. MOTHER'S MAIDEN NAME: Sophie A. Bishop

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: 705-07-9686
17. INFORMANT & ADDRESS: Donald F. Dyer, Washington, D. C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

4 a.m.

Immediate cause (a) Coronary Thrombosis — —
DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — —
DUE TO

(c) —

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. — —

19a. DATE OF OPERATION: —
19b. MAJOR FINDING OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH —
21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home
21c. (City or town) Cumberland (County) Alley (State) Md.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY — M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR? —

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 9/5/54

23. BURIAL, CREMATION, REMOVAL (Specify): burial
DATE THEREOF 9-8-1954
NAME OF CEMETERY OR CREMATORY Warfordsburg Cemetery
LOCATION (City, town, or county) Warfordsburg, Pa. (State)

DATE REC'D BY LOCAL REG. Sept. 7, 1954
REGISTRAR'S SIGNATURE [signature] M. D.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland ADDRESS Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08048

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RFD- Frostburg
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RFD - Frostburg,
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Rachel (Middle) Catherine (Last) Filer

4. DATE OF DEATH: (Month) Sept. (Day) 2nd, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov. 20th, 1880

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Webster Folk

14. MOTHER'S MAIDEN NAME: Elizabeth Eisel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) None

17. INFORMANT & ADDRESS: Benjamin Filer, Sr., RFD, Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (B) DUE TO Hypertension

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Arteriosclerosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/30, 1954 to 9/2, 1954 that I last saw the deceased alive on 8/30, 1954, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE John C Dever M. D. ADDRESS Frostburg, Md DATE SIGNED 9/3/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept. 5, 1954

NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park

LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR 9-8-54

REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR ADDRESS Joseph R. Durst, Frostburg, Md.

VS. A15—10-5

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 9 1954
BUREAU V. R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08049

CERTIFICATE OF DEATH

08044

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — MARYLAND — LENGTH OF STAY (in this place) 4 yrs 5 — HOSPITAL OR INSTITUTION OR STREET ADDRESS 406 Oldtown Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — STREET ADDRESS (If rural give location) 406 Oldtown Rd

3. NAME OF DECEASED: (Type or Print) (First) Leroy (Middle) Theodore (Last) Fisher

4. DATE OF DEATH: (Month) Sept (Day) 13 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Apr. 21 1879

9. AGE last birthday: 75 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Carman Retired

10b. KIND OF BUSINESS OR INDUSTRY: B+O RR. Co.

11. BIRTHPLACE (State or foreign country): Cumberland Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William H. Fisher

14. MOTHER'S MAIDEN NAME: Bertha Valentine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) None

16. SOCIAL SECURITY No.: 705-05-9531

17. INFORMANT & ADDRESS: E. Lewis Fisher Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
490.1 Immediate cause	(a) Uremia	6 wks.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) General Arteriosclerosis	7 yrs.
	DUE TO (c) Cancer of prostate	5 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1952, to Sept. 12, 1954, that I last saw the deceased alive on Sept. 1, 1954, and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE (Degree or title) Clay E. Barrett M.D. — ADDRESS Cumberland — DATE SIGNED 9/13/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Sept 15, 1954 — NAME OF CEMETERY OR CREMATORY Hillcrest Cem. — LOCATION (City, town, or county) Cumberland Md (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 14, 1954 — REGISTRAR'S SIGNATURE Walter R. Frantz, M.D. — 24. FUNERAL DIRECTOR Lewis Stein Inc. — ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

SEP 1?

BUCCAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08045 **CERTIFICATE OF DEATH** Reg. Dist. No. 08050 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Cumberland
LENGTH OF STAY (in this place) 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 235 Independence St.

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 235 Independence St.

3. NAME OF DECEASED: (Type or Print) (First) Ada (Middle) Marie (Last) Kauffman Fletterman
4. DATE OF DEATH: (Month) Sept. (Day) 27 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: Apr. 19, 1901
9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Keifer, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Albert R. Roby
14. MOTHER'S MAIDEN NAME: Mary Layton

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Gerald Fletterman Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinomatosis — Interval Between Onset And Death: 3 mon

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma Left Breast — 3 yr

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1951
19b. MAJOR FINDINGS OF OPERATION: Carcinoma Left Breast
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 54 to Sept 27, 19 54, that I last saw the deceased alive on Sept. 25, 19 54, and that death occurred at 6.55 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Clark Burrus M.D. Cumberland 9/29/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/30/54
NAME OF CEMETERY OR CREMATORY Reckley Cemetery
LOCATION (City, town, or county) (State) Near Paw Paw, W. Va in Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 30, 1954
REGISTRAR'S SIGNATURE Walter R. Kautz, M.D.
24. FUNERAL DIRECTOR H. Lee Silcox
ADDRESS Cumberland, Md.

OCT 4
U. S.

Within corporate limits:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08046

CERTIFICATE OF DEATH

Reg. Dist. No. 08051 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 6/2/49
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) Windsor Hotel

3. NAME OF DECEASED: (Type or Print) (First) Agnes (Middle) M. (Last) Fries

4. DATE OF DEATH: (Month) (Day) (Year) September 20, 19 54

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 8/12/1865
9. AGE last birthday: 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Barton, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Grant
14. MOTHER'S MAIDEN NAME: Margaret Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	Pulmonary Hypostasis	36 hrs.
ANTECEDENT CAUSE (B) DUE TO	Chronic Myocarditis	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO	Cerebral Arteriosclerosis	?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Senile Deterioration	?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1951, to Sept. 20 1954, that I last saw the deceased alive on Sept. 20, 1954, and that death occurred at 5:25 P.M, from the causes and on the date stated above.
SIGNATURE James E. McLean M.D. M. D. ADDRESS 49 Greene St. DATE SIGNED 9.21.54

23. BURIAL, CREMATION, REMOVAL (SPECIFY)
DATE THEREOF 9-23-1954
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 23, 1954
REGISTRAR'S SIGNATURE Hunter R. Hawk, M.D.
24. FUNERAL DIRECTOR ADDRESS Charles I. George Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-[illegible]

08047

08052

Reg. Dist. 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Check the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 2 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Apt. 4-D. Jane Frazier Village

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland

STREET ADDRESS Apt. 4-D (If rural, give location) Jane Frazier Village

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) W. (Last) Gates

4. DATE OF DEATH (Month) Sept. (Day) 3 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	Dec. 17-1874	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Lumber dealer	Gunther Co.	Hagerstown, Md.	U.S.A.

13. FATHER'S NAME: William Gates

14. MOTHER'S MAIDEN NAME: Louise Riley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	226-01-8820	(wife) Lillian Gates, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Acute cardiac failure	sudden
DUE TO	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Chronic myocarditis also had	?
DUE TO (c) Cerebral sclerosis & Arteriosclerosis with hypertention .	about 1 yr ?
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H.V. Deming M.D. M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ — DATE SIGNED Sept. 3-1954

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Sept 5 1954	Greenmount	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 3, 1954	Walter A. Hardy M.D.	Davis Stein Inc.	Cumberland Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08053

08084

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kooken Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport
STREET ADDRESS (If rural give location) 437 Walnut St.

3. NAME OF DECEASED: (Type or Print) (First) Solomon (Middle) (Last) Goff

4. DATE OF DEATH: (Month) Sept (Day) 22 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 8 Feb. 1878
9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Cemetery
11. BIRTHPLACE (State or foreign country): W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Mary Goff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Papers at nursing home Westernport, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
332 X
IMMEDIATE CAUSE (A) Central Thrombosis
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
260 X (C)

INTERVAL BETWEEN ONSET AND DEATH: 4 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep, 1953 to Sep 22, 1954, that I last saw the deceased alive on Sep 22, 1954, and that death occurred at 6 P M, from the causes and on the date stated above.

SIGNATURE James H Wolverton Jr M.D. ADDRESS Piedmont W Va DATE SIGNED 9-23-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9-25-54
NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park
LOCATION (City, town, or county) Cumberland, Md (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 23, 1954
REGISTRAR'S SIGNATURE Mrs Jean C. Kelly
24. FUNERAL DIRECTOR John Hafer, ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-5

SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08054

08085

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 22
LENGTH OF STAY (in this place) 1 hr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
STREET ADDRESS (If rural give location) 11 Welsh St.

3. NAME OF DECEASED: (Type or Print) (First) BERNADETTE (Middle) A. (Last) GOODING
4. DATE OF DEATH: (Month) Sept. (Day) 21, (Year) 1954

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 2-22-1891
9. AGE last birthday 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper
10B. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: Mary Rafferty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-10-1534
17. INFORMANT & ADDRESS: Edw. Gooding, Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A) Acute Cardiac Dilatation	2 min
ANTECEDENT CAUSE (B)	DUE TO (B) Myocarditis	5 mos
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) Acute Bronchial asthma	(5 mos) + 1 hr. [illegible]

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Post-mortectomy for Ca Left Breast — 4 yrs ago

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/14, 1954, to 9/21, 1954, that I last saw the deceased alive on 9/21, 1954, and that death occurred at 7 A M, from the causes and on the date stated above.

SIGNATURE Frank T. Harrat M. D. ADDRESS Frostburg, Md. DATE SIGNED 9/22/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9-24-54
NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery
LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR 9-23-54
REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR J. R. Durst, ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08055

08048

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 10 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Virginia COUNTY Alexandria
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Alexandria
STREET ADDRESS (If rural give location) Nightingale Trailer Court

3. NAME OF DECEASED: (Type or Print) (First) Baby (Middle) Boy (Last) Grabenstein

4. DATE OF DEATH: (Month) September (Day) 21, (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: 9/21/54

9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours 1 Min. 5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Md Cumberland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Anthony Michael Grabenstein

14. MOTHER'S MAIDEN NAME: Anna Jean Robertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Sacred Heart Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Multiple congenital malformations

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) clubbed feet, deformed hands, DUE TO

(C) underdeveloped chin, cystic Kidneys

INTERVAL BETWEEN ONSET AND DEATH: (A) [illegible] (B) None

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21-, 1954, to 9-21-, 1954, that I last saw the deceased alive on 10 [illegible] 9-21-54, and that death occurred at 11:15 A M, from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS 57 Greene St DATE SIGNED 9-21-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept 23 1954

NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park

LOCATION (City, town, or county) (State) Frostburg, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 23, 1954

REGISTRAR'S SIGNATURE Walter R. Lantz, M.D.

24. FUNERAL DIRECTOR ADDRESS Brother-in-law: Wm. E. Campbell, Jr.

VS. A15—10-

SEP 23
BUREAU

Within corporate limits DR. W.F.WILLIAMS

08056

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08049

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 41 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG
STREET ADDRESS (If rural give location) 44 MECHANIC STREET

3. NAME OF DECEASED: (Type or Print) (First) EVA (Middle) PEARL (Last) GRIFFITHS

4. DATE OF DEATH: (Month) SEPT. (Day) 26 (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: JANUARY 16, 1898
9. AGE last birthday 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): FINZEL, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN CROWE
14. MOTHER'S MAIDEN NAME: IDA RAVENSCROFT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Embolus — INTERVAL BETWEEN ONSET AND DEATH 2 days.

ANTECEDENT CAUSE (B) DUE TO Chr. Myocardial Degeneration

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Thyrotoxicosis

(C) Diabetes Mellitus

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-13 1954 to 9-26 1954 that I last saw the deceased alive on 9-26 1954 and that death occurred at 6:45 P.M., from the causes and on the date stated above.

SIGNATURE J. F. Williams M. D. ADDRESS Cumberland DATE SIGNED 9-27-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9-29-54
NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.
LOCATION (City, town, or county) (State) Garrett Co. Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 27, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Joseph R. Durst ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10

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BUREAU V. S.

Dr. Zim. Hafer Durst

M

I

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08057

08050

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland, Md
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) A. (Last) Grimes

4. DATE OF DEATH: (Month) 9 (Day) 11 (Year) 1954

5. SEX: M.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed.
8. DATE OF BIRTH: August 10 1877
9. AGE last birthday 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mine Worker
10B. KIND OF BUSINESS OR INDUSTRY: Coal Mines
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Grimes
14. MOTHER'S MAIDEN NAME: unknown

15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-01-6643
17. INFORMANT & ADDRESS: Mrs Anna Mae Dorsey

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A)	Pulmonary edema	2 days
ANTECEDENT CAUSE (S)	DUE TO (B)	Acute Myocarditis	7 "
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C)	Carcinoma Pancreas	3 mo

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-7-54, 19 ..., to 9-11-54, 19 ..., that I last saw the deceased alive on 9-10-54, 19 ..., and that death occurred at 8 1/2 M, from the causes and on the date stated above.

SIGNATURE C. Zimmerman M. D. ADDRESS Cumberland Md DATE SIGNED 9-11-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept 13-54
NAME OF CEMETERY OR CREMATORY: St. Michaels
LOCATION (City, town, or county) (State): Frostburg Md

DATE REC'D BY LOCAL REGISTRAR: Sept. 12, 1954
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: J. R. Durst
ADDRESS: Frostburg Md

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 60 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 N. Centre St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 413 N. Centre St.

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Elizabeth (Last) Hager

4. DATE OF DEATH (Month) (Day) (Year) September 16 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 10/25/1874
9. AGE last birthday: 79 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Hager
14. MOTHER'S MAIDEN NAME: Cecelia Gill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs John P Dent Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: died in sleep

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b) Chronic Myocarditis — 10 yrs
DUE TO (c) Ravages of age

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21c. (City or town) Cumberland (County) Alley (State) Md
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] Acting M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 9/16/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 9/18/54
NAME OF CEMETERY OR CREMATORY Greenmount
LOCATION (City, town, or county) Cumberland (State) Maryland

DATE REC'D BY LOCAL REG. Sept 17, 1954
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Louis Stein, Inc., ADDRESS Cumberland, Maryland.

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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08059 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 West Roberts St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 10 West Roberts St.

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Howard (Last) Helmick

4. DATE OF DEATH (Month) Sept. (Day) 30 (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	Sept 25-1886	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Millwright	Celanese Corp.	Fairmont, W.Va.	U.S.A.

13. FATHER'S NAME: Charles H.Helmick

14. MOTHER'S MAIDEN NAME: Martha Jane Morley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes W.W.I

16. SOCIAL SECURITY NO.: 234-09-4701

17. INFORMANT & ADDRESS: (wife) Goldie Helmick, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Acute cardiac failure	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Coronary sclerosis (Angina syndrome)	5 yrs.
	DUE TO (c) also had Chronic myocarditis	?

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ M. D. — DATE SIGNED Sept 30-1954

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 2, 1954	Pleasant Grove Cem	Near Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 2, 1954	Winter K. Kantz, M.D.	John J. Hafer,	"

VAN ORMER

08060

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08053

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, LENGTH OF STAY (in this place) 11 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE W.VA. COUNTY Preston
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEWBURG
STREET ADDRESS (If rural give location) BOX 34

3. NAME OF DECEASED: (Type or Print) (First) MADALINE (Middle) B. (Last) HELMS

4. DATE OF DEATH: (Month) SEPT. (Day) 15 (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: AUG. 28, 1906
9. AGE last birthday 48 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): W.VA. (Preston Co)
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. REESE
14. MOTHER'S MAIDEN NAME: ALLIE SQUIRES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Memorial Hospital Records, Cumberland Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

44

IMMEDIATE CAUSE (A) Acute Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 days

ANTECEDENT CAUSE (S) DUE TO (B) Nephro-sclerosis — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertensive Vascular Disease — 10 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION.
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4 Sept., 1954, to 15 Sept., 1954 that I last saw the deceased alive on 14 Sept., 1954, and that death occurred at 7:35 AM, from the causes and on the date stated above.

SIGNATURE W. A. Van Ormer M.D. ADDRESS Cumberland, Md DATE SIGNED 15 Sept. 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Sept. 18, 1954
NAME OF CEMETERY OR CREMATORY Reedsville, Cemetery
LOCATION (City, town, or county) (State) Reedsville, W.Va.

DATE REC'D BY LOCAL REGISTRAR Sept. 15, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-

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SEP 21 1954
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08054

CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. VAN ORMER

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 19 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY Garrett
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEMPTON
STREET ADDRESS (If rural give location) Main St.,

3. NAME OF DECEASED: (Type or Print) (First) BERTHA (Middle) Belle (Last) HILTON

4. DATE OF DEATH: (Month) (Day) (Year) SEPT. 24, 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: NOV. 6, 1886
9. AGE last birthday 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL REED
14. MOTHER'S MAIDEN NAME: Catherine CHURCH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No, (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Post operative shock	2 days.
DUE TO (B)	Chronic myocarditis c̄ acute	2 yrs.
DUE TO (C)	myocardial failure.	2 yrs.
	Duodenal ulcer with pyloric obstruction	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. abdominal adhesions. Pulmonary tuberculosis - arrested. 3 yrs

19A. DATE OF OPERATION: 9-22-54
19B. MAJOR FINDINGS OF OPERATION: Pyloric obstruction - due to ulcer and adhesions
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-10, 1954 to 9-24, 1954 that I last saw the deceased alive on 9-24, 1954, and that death occurred at 2:10 PM, from the causes and on the date stated above.

SIGNATURE Donald B. Irvine M.D. ADDRESS Medical Bldg DATE SIGNED 9-24-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9/27/54
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) (State) Thomas, W. Va.

DATE REC'D BY LOCAL REGISTRAR Sept. 24, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR H. Wayne George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-

SEP 28 1934

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08062

08055

DR. LEY

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 13 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 231 INDEPENDENCE STREET

3. NAME OF DECEASED: (Type or Print) (First) BENJAMIN (Middle) B. (Last) KAEFER

4. DATE OF DEATH: (Month) SEPT. (Day) 9 (Year) 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: MAY 20, 1894
9. AGE last birthday 60 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist NONE
10B KIND OF BUSINESS OR INDUSTRY: B&O Bolt & Forge
11. BIRTHPLACE (State or foreign country): MARYLAND, Woodland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY KAEFER
14. MOTHER'S MAIDEN NAME: Elizabeth Anthony

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-12-5646
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Myocardial Degeneration
DUE TO
ANTECEDENT CAUSE (S) (B) Arteriosclerosis
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/23, 1954, to 9/9, 1954, that I last saw the deceased alive on 9/9, 1954, and that death occurred at 4:25 A.M., from the causes and on the date stated above.

SIGNATURE Leo H. Ley Jr. M.D. ADDRESS 456 N. Centre St. DATE SIGNED 9/10/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Sept. 11, '54
NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park
LOCATION (City, town, or county) (State) Frostburg, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 11, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Maryland

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08063

08086

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-

1. PLACE OF DEATH.
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 73 Ormond St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,
STREET ADDRESS (If rural give location) 73 Ormand Street

3. NAME OF DECEASED: (Type or Print) (First) Jacob (Middle) Lewis (Last) Kaplon

4. DATE OF DEATH (Month) (Day) (Year) Sept. 24th, 1954

5. SEX Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: Feb. 10th, 1884

9. AGE last birthday: 70 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber Dealer

10B. KIND OF BUSINESS OR INDUSTRY: Lumber Business

11. BIRTHPLACE (State or foreign country): Urburg, Lithuania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anselm Kizell

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-32-2955

17. INFORMANT & ADDRESS: Phyllis Kaplon, Frostburg, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Bronchogenic Carcinoma — 1 yr

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Invasion

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1953 to Sept., 1954, that I last saw the deceased alive on Sept 23, 1954, and that death occurred at 7 P.M, from the causes and on the date stated above.

SIGNATURE John C Diamond M. D. ADDRESS Frostburg, Md DATE SIGNED 9-25-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 9-27-1954

NAME OF CEMETERY OR CREMATORY East View Cemetery

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR 9-27-54

REGISTRAR'S SIGNATURE Mrs Nancy M Roe

24. FUNERAL DIRECTOR ADDRESS Joseph R. Durst, Frostburg, Md.

RECEIVED
SEP 30 1954
BUREAU V. S.

Outside of City Limits

08097

08064

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Vocke Rd.R.F.D.#5

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural) Cumberland

STREET ADDRESS (If rural, give location) Vocke Rd.R.F.D.#5 Box 272

3. NAME OF DECEASED: (Type or Print) (First) Erma (Middle) H. (Last) Keifer

4. DATE OF DEATH (Month) Sept. (Day) 29 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH: April 13-1914

9. AGE last birthday: 40 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): R.N.Nurse & Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Private duty

11. BIRTHPLACE (State or foreign country): Corrigansville,Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oscar M.Llewellyn

14. MOTHER'S MAIDEN NAME: Elisa May Mathews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 214-16-2847

17. INFORMANT & ADDRESS: Mrs.Thelma Llewellyn,Green Spring,W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intracranial hemorrhage due to a 22 caliber	sudden
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Marlin rifle bullet in brain through mouth.	
DUE TO		
	(c) Self inflicted.	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☒ CAUSE OF DEATH.

21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home

21c. (City or town) (rural) (County) Cumberland,Allegany,Md. (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) about 8.00 Sept.29/54 A.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Put muzzle of rifle in mouth and pushed the trigger.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V.Deming M.D. H.V.Deming M.D. M. D.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Sept.29-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Oct 2, 1954

NAME OF CEMETERY OR CREMATORY St. Peter & Paul

LOCATION (City, town, or county) Cumberland (State) Maryland

DATE REC'D BY LOCAL REG. Oct. 4, 1954

REGISTRAR'S SIGNATURE Walter K. Hank, M.D.

24. FUNERAL DIRECTOR Louis Stern, Inc.

ADDRESS Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

08087 08065

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Apply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (In this place) 81 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frostburg Police Station

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 29 Bealls Lane

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) D. (Last) Keller
4. DATE OF DEATH (Month) Sept. (Day) 26 (Year) 19 54
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH: Dec. 19-1872
9. AGE last birthday: 81 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: Beall High School
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J. Keller
14. MOTHER'S MAIDEN NAME: Lutie Ruhena
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Durst Funeral Home

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	Coronary occlusion	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	Arteriosclerosis	?
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H. V. Deming M.D. M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED Sept. 26-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 9-29-54
NAME OF CEMETERY OR CREMATORY Elbg. Memorial Park
LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR 9-28-54
REGISTRAR'S SIGNATURE Nancy N. Roe
24. FUNERAL DIRECTOR J. R. Durst,
ADDRESS Frostburg, Md.

VS. A15A - 5 - 53

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08056

CERTIFICATE OF DEATH

08066

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 72 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 611 Hill Top Drive

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 611 Hill Top Drive

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) H. (Last) Korns

4. DATE OF DEATH: (Month) Sept (Day) 7 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: July 7 1882
9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own House
11. BIRTHPLACE (State or foreign country): Cumberland, Allegany Co, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Spoerl
14. MOTHER'S MAIDEN NAME: Elizabeth Herpick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Louis Spoerl, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocarditis Chronic 2 — Interval Between Onset And Death: 2 years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Coronary occlusion 1 — Immediate

DUE TO (c) Dud suddenly

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1953, to Sept 7, 1954, that I last saw the deceased alive on Sept 7, 1954 and that death occurred at 10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) F. Alan G. Murray M.D. ADDRESS Cumberland Md DATE SIGNED Sept 8 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept 10 1954
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Sept 10, 1954
REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Within corporate limits.

05057

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. HIMMELLWRIGHT

CERTIFICATE OF DEATH

08067

Reg. Dist. No. 7

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 1

M

1

1. PLACE OF DEATH:
COUNTY: ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
LENGTH OF STAY (In this place): 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MARYLAND COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural give location): 40 ELDER STREET

3. NAME OF DECEASED: (Type or Print) (First) DOROTHY (Middle) E. (Last) LEWIS

4. DATE OF DEATH: (Month) SEPT. (Day) 22 (Year) 19 54

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: OCT. 21, 1911

9. AGE last birthday 42 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALONZO SLIDER

14. MOTHER'S MAIDEN NAME: VIOLA DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE — (A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSE (S) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Metastatic Sarcoma — DUE TO

(C) Lymphosarcoma, retroperitoneal — unknown

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 6-29-54

19B. MAJOR FINDINGS OF OPERATION Retro-peritoneal lymphosarcoma

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 20, 1954 to Sept 22, 1954, that I last saw the deceased alive on Sept 22, 1954, and that death occurred at 4:50A M, from the causes and on the date stated above.

SIGNATURE: S. Overton Himmellwright M.D. — ADDRESS: 202 Virginia Ave — DATE SIGNED: Sept 22, 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — **DATE THEREOF:** Sept. 25, 1954 — **NAME OF CEMETERY OR CREMATORY:** Davis Memorial Cem. — **LOCATION (City, town, or county) (State):** Oldtown, Maryland

DATE REC'D BY LOCAL REGISTRAR: Sept. 24, 1954 — **REGISTRAR'S SIGNATURE:** Walter R. Franke M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer, Cumberland, Maryland

SEP 28 1931
BUREAU V. S.

08088 **MARYLAND STATE DEPARTMENT OF HEALTH** 08068

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS Center Hotel, Main St.,	STREET ADDRESS (If rural, give location) Center Hotel, Main St.,

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) [illegible] (Last) [illegible]			4. DATE OF DEATH (Month) Sept. (Day) [illegible] (Year) 19		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) [illegible]	8. DATE OF BIRTH Feb. 17, 1[illegible]	9. AGE last birthday [illegible] yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible] engineer	10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	11. BIRTHPLACE (State or foreign country) [illegible]	12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME William L. [illegible]		14. MOTHER'S MAIDEN NAME [illegible]			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service) [illegible]	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Mrs. [illegible]			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 1 hr.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Heart Disease — years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sep. 17, 1954, to Sept. 24, 1954, that I last saw the deceased alive on Sept. 24, 1954, and that death occurred at 2:30p. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John B. Davis	M.D.	Frostburg, Md	9/24/54.

23. BURIAL, CREMATION REMOVAL (Specify) [illegible]	DATE THEREOF [illegible]	NAME OF CEMETERY OR CREMATORY [illegible]	LOCATION (City, town, or county) (State) [illegible]
DATE REC'D BY LOCAL REG. 9-26-54	REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe	24. FUNERAL DIRECTOR H. Wayne Geo[illegible]	ADDRESS [illegible]

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 30 1954
BUREAU V. S.

08058

08070
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 6 Wks.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 135 Bedford St.

3. NAME OF DECEASED: (Type or Print) (First) Jessie (Middle) J. (Last) Lumon
4. DATE OF DEATH (Month) Sept. (Day) 9 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: May 8 1881
9. AGE last birthday: 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Retd.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore Luman
14. MOTHER'S MAIDEN NAME: Annie Mac Beth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-16-7477
17. INFORMANT & ADDRESS: Sacred Heart Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Chronic Myocarditis — Interval between onset and death: 10 yrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b) Myocardial Failure — 12 hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture of rt hip — 1 mo - 15 days

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home
21c. (City or town) Cumberland (County) Allegany (State) Md
21d. TIME OF INJURY (Month) 7 (Day) 24 (Year) 54 (Hour) 2 P M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☑
21f. HOW DID INJURY OCCUR? Stumbled and fell

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] Acting M.D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 9/10/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF Sept 11, 1954
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Sept. 10, 1954
REGISTRAR'S SIGNATURE Walter L. Frank, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc.
ADDRESS Cumberland Md

VS. A15A - 5 - 53

DR. FAW

08059

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08071

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
LENGTH OF STAY (in this place) 42 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE WEST VIRGINIA COUNTY Mineral
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY,
STREET ADDRESS (If rural give location) R.F.D.#1

3. NAME OF DECEASED: (Type or Print) (First) ESTELLA (Middle) Virginia (Last) MALCOLM

4. DATE OF DEATH: (Month) SEPT. (Day) 27 (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: JUNE 25 1892
9. AGE last birthday: 63 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]
10B. KIND OF BUSINESS OR INDUSTRY: [illegible]
11. BIRTHPLACE (State or foreign country): W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM LEWIS
14. MOTHER'S MAIDEN NAME: REBECCA MC BRIDE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. [illegible]
17. INFORMANT & ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174X

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) Sarcoma of uterus uteri — INTERVAL BETWEEN ONSET AND DEATH: Appx 3 years

DUE TO

(B) Cachexia

DUE TO

(C) Arterial embolus - left femoral — Aug 31, 1954

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. artery with gangrene lower left extremity

19A. DATE OF OPERATION: Aug 21, 1954
19B. MAJOR FINDINGS OF OPERATION: Sarcoma - inoperable uterus
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 17, 1954, to Sep 27, 1954, that I last saw the deceased alive on Sep 26, 1954, and that death occurred at 2.02 AM. from the causes and on the date stated above.

SIGNATURE: W M Faw Jr. M. D.
ADDRESS: Cumberland Md
DATE SIGNED: Sept. 28, 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept. 2, 1954
NAME OF CEMETERY OR CREMATORY: Three Churches Cemetery
LOCATION (City, town, or county) (State): Three Churches, W. Va.

DATE REC'D BY LOCAL REGISTRAR: Sept. 29, 1954
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: [illegible]
ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10

08072

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08089 **CERTIFICATE OF DEATH** Reg. Dist. No. 6

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport
LENGTH OF STAY (in this place) 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 138 Church St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport
STREET ADDRESS (If rural give location) 138 Church ST

3. NAME OF DECEASED: (Type or Print) (First) KATHERINE (Middle) (Last) McCarthy

4. DATE OF DEATH: (Month) (Day) (Year) Sept 24 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 16 Dec 1869

9. AGE last birthday: 84 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Brooklyn, N. Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John McCarthy

14. MOTHER'S MAIDEN NAME: Annie Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs Jas. L. Mansfield, Westernport, Church ST.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A)	Pulmonary Edema	1 Day
ANTECEDENT CAUSE (B) DUE TO	Chronic Myocarditis	2 Years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO	Arteria-sclerosis	2 Years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY None

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 10, 1951, to Sept. 24, 1954, that I last saw the deceased alive on Sept 23, 1954., and that death occurred at 4:00 A M, from the causes and on the date stated above.

SIGNATURE Paul R Wilson M. O. ADDRESS Piedmont, W. Va. DATE SIGNED Sept. 25, 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 9-27-54

NAME OF CEMETERY OR CREMATORY St. Peters Cemetery

LOCATION (City, town, or county) (State) Westernport, Md

DATE REC'D BY LOCAL REGISTRAR Sept 27, 1954

REGISTRAR'S SIGNATURE Mrs Jos C. Kelly

24. FUNERAL DIRECTOR E. S. Boal ADDRESS Westernport, Md.

SEP 29 1954

BUREAU V. S.

08060

08073

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland

LENGTH OF STAY (in this place): 10 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 923 Maryland Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland

STREET ADDRESS (If rural, give location): 923 Maryland Avenue

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	H.	Mc Cusker	9	6	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	married	Dec. 1, 1876	77 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Crane Helper	Railroad	Hancock, Md.	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Jacob Mc Cusker	Emily Fiser Mc Cusker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
no	none	Luther H. Mc Cusker, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) DUE TO: Fractured Skull	immediate
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO:	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Hypertension — yrs.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY: Home	21c. City or town (County) (State): Cumberland Alleg Md.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9/6/54 8:15 P.M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☑	21f. HOW DID INJURY OCCUR? Fell, flight of stairs striking head

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: H. Williams M.D. — Acting CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ M. D. — DATE SIGNED: 9/6/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	9-9-1954	St. Mary's Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Sept. 7, 1954	Walter L. Grady, M.D.	James F. Scarpelli, Cumberland, Md.

VS. A15A - 5 - 53

Within corporate DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08074

08061

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 5 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVENUE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 347 BEDFORD STREET

3. NAME OF DECEASED: (Type or Print) (First) IRENE (Middle) L. (Last) MILLER

4. DATE OF DEATH: (Month) (Day) (Year) SEPT. 5 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: AUG. 25, 1918
9. AGE last birthday 36 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own House
11. BIRTHPLACE (State or foreign country): LONACONING, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH W. WILAND
14. MOTHER'S MAIDEN NAME: MARGARET L. LYDON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) Carcinoma, breast. Right with — INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs.
DUE TO
(B) metastasis to lungs and liver — 1 yr
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma Rt breast with lymph node metastasis
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, 19 , to Sep. 5, 1954, that I last saw the deceased alive on Sep 5, 1954, and that death occurred at 12,45PM, from the causes and on the date stated above.

SIGNATURE: W M Faw Jr. M. D. ADDRESS: Cumberland Md DATE SIGNED: Sep 5, 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept 8 1954
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR: Sept. 8, 1954
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: William H. Kight ADDRESS: Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-

1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08062

CERTIFICATE OF DEATH

Reg. Dist. No. 08075

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-5

1. PLACE OF DEATH:
COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
MARYLAND LENGTH OF STAY (in this place): 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Pennsylvania COUNTY: Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hyndman Rural
STREET ADDRESS (If rural give location): Londonderry Township

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print): Jeremiah Franklin Monnett

4. DATE OF DEATH: (Month) (Day) (Year): Sept. 15 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Jan. 8, 1893

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer and Fireman

10B. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Cumberland, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph W. Monnett

14. MOTHER'S MAIDEN NAME: Anna Elizabeth McKinzey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes
(If Yes, give war or dates of service): 1918

16. SOCIAL SECURITY NO.: 214 07 5466

17. INFORMANT & ADDRESS: William Monnett, Hyndman, Pa. RD#1

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) DUE TO: Carcinoma of Lungs (Bilateral) — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

ANTECEDENT CAUSE (B) DUE TO:

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1954, to Sep. 15, 1954, that I last saw the deceased alive on Sep. 15, 1954, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE: John A Topper MD M.D. ADDRESS: Hyndman DATE SIGNED: 9.16.54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: Sept. 19, 1954

NAME OF CEMETERY OR CREMATORY: Monnett-Lichlatter Cemetery

LOCATION (City, town, or county) (State): Ridgeley, W.Va.

DATE REC'D BY LOCAL REGISTRAR: Sept. 17, 1954

REGISTRAR'S SIGNATURE: Walter L. Raup M.D.

24. FUNERAL DIRECTOR ADDRESS: Harvey H. Zeigler, Hyndman, Pa.

Within corporate limits

DR. DAUGHERTY

08076

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08063

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
MARYLAND
LENGTH OF STAY (in this place) 15 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RT. #1 OLDTOWN
STREET ADDRESS (If rural give location) Rt. 1 Oldtown Md.

3. NAME OF DECEASED: (Type or Print) (First) W. (Middle) PERCY (Last) NIXON

4. DATE OF DEATH: (Month) SEPT. (Day) 10 (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED

8. DATE OF BIRTH: 5/19/04

9. AGE last birthday: 50 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trucker

10B. KIND OF BUSINESS OR INDUSTRY: B&O R.R.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELWOOD NIXON

14. MOTHER'S MAIDEN NAME: CLARA TWIGG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-10-2235

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Carcinoma of lung.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 8 mo.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 15, 1954, to Sept. 10, 1954, that I last saw the deceased alive on Sept. 10, 1954, and that death occurred at 2:15 P M, from the causes and on the date stated above.

SIGNATURE Leslie E. Daugherty M. D. ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept 13, 1954

NAME OF CEMETERY OR CREMATORY Pine Hill Cem.

LOCATION (City, town, or county) (State) Oldtown Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 13, 1954

REGISTRAR'S SIGNATURE Winter R. Darby, M.D.

24. FUNERAL DIRECTOR Louis Stein Inc.

ADDRESS Cumb. Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-

Received
SEP 16 1954
BUREAU OF

Dr. Durrett
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08077

08064

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 502 Linden St.,

3. NAME OF DECEASED: (Type or Print) (First) Gertrude (Middle) E. (Last) Oglebay

4. DATE OF DEATH (Month) Sept. (Day) 12 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Feb. 14, 1884
9. AGE last birthday 70 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: August Krause
14. MOTHER'S MAIDEN NAME: Margaret Books

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO, (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-18-4258
17. INFORMANT & ADDRESS: Mrs. Charles W. Chenowith Cumb. Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

ANTECEDENT CAUSE (B) DUE TO Cirrhosis of Liver — 8 wks

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 1954, to Sept. 12, 1954, that I last saw the deceased alive on Sept. 12, 1954 and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Clark Durrett M.D. M. D. ADDRESS 236 Vanur DATE SIGNED 9/15/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept. 15, 1954
NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Sept. 15, 1954
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: Charles L. George
ADDRESS: Cumberland, Md.

M

I

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 -

RECEIVED
SEP 21 1
BUREAU V

08090 08078

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 9½hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED: (Type or Print) (First) Catherine (Middle) Knapp (Last) O Rourke
4. DATE OF DEATH (Month) Sept. (Day) 16 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: NOV. 9.1879
9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christopher J Knapp
14. MOTHER'S MAIDEN NAME: Susanna Wade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mr. Issac O Rourke, Midland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Shock from burns received	9hr 15 min
	DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)		
	DUE TO		
	(c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
21c. (City or town) Midland (County) Alleg (State) Md

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 45 p M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☑
21f. HOW DID INJURY OCCUR? Clothes became ignited while burning trash

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. Williams
Acting M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 9/17/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF Sept. 20.1954
NAME OF CEMETERY OR CREMATORY Belvedere Cemetery
LOCATION (City, town, or county) Midland, Md. (State)

DATE REC'D BY LOCAL REG. 9-18-54
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

SEP 20 1954
BURLAU V. S.

Send to appropriate Health Officer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. TOLSON 08065 **CERTIFICATE OF DEATH** 08079

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARTON
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) DAVID (Middle) Clark (Last) PRESTON

4. DATE OF DEATH: (Month) SEPT. (Day) 15, (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: JUNE 1, 1880

9. AGE last birthday 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED Coal Miner - Coal Mines

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Meshach [redacted] PRESTON

14. MOTHER'S MAIDEN NAME: ANNIE GREENHORN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-09-9518

17. INFORMANT & ADDRESS. MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Carcinoma - urinary bladder

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. arteriosclerosis

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1-54 A., to 8-15-54, that I last saw the deceased alive on 8-14-54 and that death occurred at 6:20 A M, from the causes and on the date stated above.

SIGNATURE Howard R. Dolan, M.D. ADDRESS M.D. Cumberland Md. DATE SIGNED 9-15-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 9-18-54

NAME OF CEMETERY OR CREMATORY Laurel Hill Cem

LOCATION (City, town, or county) (State) Mascaw Md

DATE REC'D BY LOCAL REGISTRAR Sept. 16, 1954

REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR E. L. Bane ADDRESS Westernport Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-5

SEP 21 1954
JREAU V

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08080

08066 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 7/28/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 323 Baltimore Avenue

3. NAME OF DECEASED: (Type or Print) (First) Clara (Middle) (Last) Price

4. DATE OF DEATH (Month) (Day) (Year) September 13, 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: 10/1/1869
9. AGE last birthday 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired -
10B. KIND OF BUSINESS OR INDUSTRY: Bookkeeper Prices General Store
11. BIRTHPLACE (State or foreign country): Maryland, Cumberland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles Price
14. MOTHER'S MAIDEN NAME: Betty Maier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary Hypostasis — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

ANTECEDENT CAUSE (S) DUE TO (B) Cerebral Hemorrhage — 3 mos.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cerebral Arteriosclerosis — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile Deterioration — ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1954, to Sept. 14, 1954, that I last saw the deceased alive on Sept. 13, 1954, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

SIGNATURE James B. McLean M.D. M. D. ADDRESS 49 Greene St. DATE SIGNED 9-14-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept. 16, 1954
NAME OF CEMETERY OR CREMATORY: East View Cemetery
LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR: Sept. 16, 1954
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Md. ADDRESS

M

I

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 -

RECEIVED
SEP 21 1954
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08081

08067 **CERTIFICATE OF DEATH**

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-

1. PLACE OF DEATH:
COUNTY [illegible] MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD
LENGTH OF STAY (in this place) 9/7/54
HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible]

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE [illegible] COUNTY [illegible]
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mar[illegible], Rural
STREET ADDRESS (If rural give location) R.F.D. #6, [illegible]

3. NAME OF DECEASED: (Type or Print) (First) Jessy (Middle) PRICE (Last) RAWLINGS

4. DATE OF DEATH: (Month) 9-10-54 (Day) (Year) 19

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married | 8. DATE OF BIRTH: 7-11-80 | 9. AGE last birthday 74 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Dry Cleaner's
10B. KIND OF BUSINESS OR INDUSTRY: Economy Dye Wks. Star
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Rawlings
14. MOTHER'S MAIDEN NAME: Magdalene Rost

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) Spanish-American
16. SOCIAL SECURITY NO. 214-05-7085
17. INFORMANT & ADDRESS: Mrs. Amelia Dreyer Rawlings, Cumberland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A) Uremia	2 weeks
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Rectal Hemorrhage	4 days
	DUE TO (C) Generalized Arteriosclerosis	2 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. ..., 1953, to 9/1 D. ..., 1954 that I last saw the deceased alive on 9/1 D. ..., 1954, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE George M. Rymer M. D. ADDRESS Cumberland Md DATE SIGNED 9/11/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Sept. 12, '54 | NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 11, 1954 | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D. | 24. FUNERAL DIRECTOR ADDRESS John J. Hafer, Cumberland, Maryland

08068

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08082

Item 9, Film 170 8-20-54 et DR. W.T. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, rural
STREET ADDRESS (If rural give location) ROUTE #3

3. NAME OF DECEASED: (First) ROY (Middle) WILLIAM (Last) ROSE

4. DATE OF DEATH: (Month) SEPT. (Day) 10, (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: JULY 1, 1897

9. AGE last birthday 56 // 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN

10B. KIND OF BUSINESS OR INDUSTRY: KELLY TIRE CO.

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAVID C. ROSE

14. MOTHER'S MAIDEN NAME: HALLIE MAE FERNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-07-0130

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6 hrs.

ANTECEDENT CAUSE (B) DUE TO Coronary Thrombosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Healing Ulcer Hypertension

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-21-54 to 9-10-1954, that I last saw the deceased alive on 9-9-, 1954, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

SIGNATURE Wm. F. Williams M.D. ADDRESS Cumberland DATE SIGNED 9-10-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 9/12/54 — NAME OF CEMETERY OR CREMATORY Centerville Memorial — LOCATION (City, town, or county) (State) Centerville, Pa.

DATE REC'D BY LOCAL REGISTRAR Sept. 11, 1954 — REGISTRAR'S SIGNATURE Hunter R. Hantz, M.D.

24. FUNERAL DIRECTOR ADDRESS H. Lee Silcox- Cumberland, Md.

08083

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08091 **CERTIFICATE OF DEATH** Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg — LENGTH OF STAY (in this place) 1 Week	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital	STREET ADDRESS (If rural give location) Parkersburg Road

3. NAME OF DECEASED: (Type or Print) (First) Matilda (Middle) Porter (Last) Seifarth — 4. DATE OF DEATH: (Month) Sept. (Day) 2nd, (Year) 1954

5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married — 8. DATE OF BIRTH: Nov. 25th, 1879 — 9. AGE last birthday 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10B. KIND OF BUSINESS OR INDUSTRY: Housework — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Porter — 14. MOTHER'S MAIDEN NAME: Rachel Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT & ADDRESS: William Seifarth, Eckhart, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Massive Cerebral Hemorrhage — 7 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertensive Heart Disease — DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. First and Second Degree Burns — 7 days

19A. DATE OF OPERATION: NONE — 19B. MAJOR FINDINGS OF OPERATION ✓ — 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME — 21C. WHERE DID INJURY OCCUR? (City or town) ECKHART (County) ALLEGANY (State) MD.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) AUG. 25-1954 48. M. — 21E. INJURY OCCURRED While at work ☑ Not while at work ☐ — 21F. HOW DID INJURY OCCUR? Developed "stroke" and fell with pan of hot tea

22. I hereby certify that I attended the deceased from 8/25, 1954, to 9/2, 1954, that I last saw the deceased alive on 9/2, 1954, and that death occurred at 7:00 A M, from the causes and on the date stated above.

SIGNATURE Martin M. Rothstein M.D. — ADDRESS 48 Broadway Frostburg, Md. — DATE SIGNED 9/3/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: Sept. 4, 1954 — NAME OF CEMETERY OR CREMATORY: Porter Cemetery — LOCATION (City, town, or county): Eckhart, (State) Md

DATE REC'D BY LOCAL REGISTRAR: 9-4-54 — REGISTRAR'S SIGNATURE: Mr. Nancy H. Roe — 24. FUNERAL DIRECTOR: Joseph R. Durst, — ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-5

RECEIVED
SEP 9
BUREAU V. S.

Within corporate limits. 08069 08084

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pa. COUNTY ~~Somerset~~ Bedford
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Hyndman
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Edith (Middle) J. (Last) Shuwack

4. DATE OF DEATH (Month) Sept. (Day) 22 (Year) 19 54

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: Jan. 7-1883
9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Somerset, Co. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Ware
14. MOTHER'S MAIDEN NAME: Mary Miller Coughenour

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of [redacted])
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral hemorrhage (left hemisphere)	4 days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Cerebral vascular sclerosis.	?
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Deming M.D. H. V. Deming M.D. M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 9-23-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF Sept. 26, 1954
NAME OF CEMETERY OR CREMATORY Hyndman Cem
LOCATION (City, town, or county) (State) Hyndman, Penna.

DATE REC'D BY LOCAL REG. Sept. 24, 1954
REGISTRAR'S SIGNATURE Winter R. Hartz, M.D.
24. FUNERAL DIRECTOR Harvey H. Ziegler, " ADDRESS "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

08085

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. W.F.WILLIAMS 08070 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-5

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 1014 ELLA AVENUE,

3. NAME OF DECEASED: (First) BENJAMIN (Middle) H. (Last) SIRBAUGH
4. DATE OF DEATH: (Month) SEPT., (Day) 16, (Year) 1954
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: APRIL 12, 1889
9. AGE last birthday 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Mosquito Control Program.
10B. KIND OF BUSINESS OR INDUSTRY: City Health Dept.
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? Great Canada U.S.A.

13. FATHER'S NAME: A. A. SIRBAUGH
14. MOTHER'S MAIDEN NAME: SARAH LUDWIG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 21-710-6278
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Chronic Myocardial	
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Degeneration DUE TO	?
	(C)	1
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9.15., 1954 to 9.16 1954 that I last saw the deceased alive on 9.16., 1954 and that death occurred at 11:17 M, from the causes and on the date stated above.
SIGNATURE W. F. Williams M. D. ADDRESS Cumberland DATE SIGNED 9.17.54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9-19-54
NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 18, 1954
REGISTRAR'S SIGNATURE Viola R. Lantz, M.D.
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli Cumberland, Md.

SEP 21 1954

BUREAU V[illegible] S[illegible]

Within corporate limit W.F.WMS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08086

08071 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
LENGTH OF STAY (in this place) 12 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
STREET ADDRESS (If rural give location) 204 GREENE STREET

3. NAME OF DECEASED: (Type or Print) (First) FRANK (Middle) (Last) SMITH

4. DATE OF DEATH: (Month) SEPT. (Day) 20 (Year) 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: JULY 8, 1894
9. AGE last birthday 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Western Md. R. R.
11. BIRTHPLACE (State or foreign country): THOMAS, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PETER SMITH
14. MOTHER'S MAIDEN NAME: EMMA SOMERFIELD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Mrs Frank Smith, 204 Greene St.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 IMMEDIATE CAUSE (A) Chronic Myocardial Degeneration

ANTECEDENT CAUSE (S) DUE TO (B) Coronary Artery Heart Disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Uremia

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8.8, 1950, to 9.20, 1954, that I last saw the deceased alive on 9-19, 1954, and that death occurred at 7:00 AM from the causes and on the date stated above.

SIGNATURE W. F. Williams M. D. ADDRESS Cumberland DATE SIGNED 9-21-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Sept. 22, 1954
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 22, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles I. George, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10

SEP 25
BUREAU V.

08087

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08072 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland — LENGTH OF STAY (in this place) Lifetime	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 817 Edgewood Drive	STREET ADDRESS (If rural give location) 817 Edgewood Drive

3. NAME OF DECEASED: (Type or Print) (First) Harry (Middle) Mullen (Last) Smith

4. DATE OF DEATH: (Month) Sept. (Day) 28 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Aug. 16, 1891

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Inspector of Transportation

10b. KIND OF BUSINESS OR INDUSTRY: W.M.R.R.

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles H. Smith

14. MOTHER'S MAIDEN NAME: Matilda White

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 705-10-6880

17. INFORMANT & ADDRESS: Emily M. Smith Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute coronary occlusion — Interval Between Onset And Death: 1 hour

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) arteriosclerosis — 1 year

DUE TO

(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-6-1953, to 9-28-1954, that I last saw the deceased alive on 9-28-1954, and that death occurred at 1:15 PM, from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) MD ADDRESS 5 Vaccum St. DATE SIGNED 9-29-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10/1/54 — NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery — LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 30, 1954 — REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR H. Lee Silcox-m Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

OCT 4
U. S.

08098

08089

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 1

1. PLACE OF DEATH:
COUNTY ..lle any MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ..ri.. ..r
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY ..11 ..
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Sprin ..r
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)

4. DATE OF DEATH (Month) Sept. (Day) 6 (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Ma	Whe	..n.le	..,12,1951	3 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
none		Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
George Steinmetz	Mary Burton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	None	Mrs George Steinmetz, ..r.. ..;

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) DUE TO Myocardial Failure Congenital C.V.D.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: (a) 2 yrs

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) Spring Hope	(County) Alley	(State) Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 9/6/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Sept. 8 1954	Rose Hill Cemetery	Cumberland,	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 7, 1954	Mrs. Fay Duckworth mnt.	Charles I. ..r.., ..., ...l.nd.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

Write corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08090

08073 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STATE Maryland
LENGTH OF STAY (in this place) 45 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 134 Arch Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,
STREET ADDRESS (If rural give location) 134 Arch Street

3. NAME OF DECEASED: (Type or Print) (First) Alice (Middle) G. (Last) Stickley

4. DATE OF DEATH: (Month) Sept. (Day) 24 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Dec. 19, 1877

9. AGE last birthday 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Petersburg, West Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Snyder Stickley

14. MOTHER'S MAIDEN NAME. Sarah See

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs. Venie Gross, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
IMMEDIATE CAUSE (A) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: **19B. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) **21B. PLACE** (Home, farm, factory, OF INJURY street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. **21E. INJURY OCCURRED** While at work ☐ Not while at work ☐ **21F. HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from 6-5, 19 54, to 9-24, 19 54, that I last saw the deceased alive on 9-24, 19 54, and that death occurred at 11:50 A M, from the causes and on the date stated above.

SIGNATURE AND M.D. Ralph L. Baccini — ADDRESS 62 Greene St. Cumberland Md — DATE SIGNED 9-27-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Sept. 28, 1954 — NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery — LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 28, 1954 — REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer — ADDRESS Cumberland, Maryland

VS. A15 — 10 - [illegible]

OCT 5
V. S.

08074

08091

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 2 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland Md.
STREET ADDRESS 311 Pulaski Street (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Catherine (Middle) A. (Last) Taylor

4. DATE OF DEATH (Month) 9 (Day) 6 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 6 1877

9. AGE last birthday: 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Mt Savage Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Barrett

14. MOTHER'S MAIDEN NAME: — — Reynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Sacred Heart Hosp. Cumb. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cardio renal Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture of left femur — 1 mo 15 days

19a. DATE OF OPERATION: —

19b. MAJOR FINDING OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town) Cumberland (County) Allegany (State) Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 7/24/54 — P.M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR? Fell when leg became buggy

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] Acting M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ — DATE SIGNED 9/8/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Sept. 9 1954 — NAME OF CEMETERY OR CREMATORY St Patricks Cem — LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Sept. 7 1954 — REGISTRAR'S SIGNATURE Victor L. Fauntz, M. D.

24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumberland Md

Outside of City Limits

08099 08092

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN La Vale
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Hugh (Middle) Stanley (Last) Torbet

4. DATE OF DEATH (Month) Sept (Day) 14 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: May 14, 1893

9. AGE last birthday: 61 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Inspector

10b. KIND OF BUSINESS OR INDUSTRY: State Health Dept

11. BIRTHPLACE (State or foreign country): Lonaconing, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Torbet

14. MOTHER'S MAIDEN NAME: Jean Lynn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) World War #1

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs Grace Torbet (Wife)

18. MEDICAL CERTIFICATION La Vale, Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Acting M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 9/15/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Sept 17, 1954 — NAME OF CEMETERY OR CREMATORY Arlington Cemetery — LOCATION (City, town, or county) Arlington, (State) Va.

DATE REC'D BY LOCAL REG. Sept. 15, 1954 — REGISTRAR'S SIGNATURE Charles K. Grant, M.D.

24. FUNERAL DIRECTOR George Eichhorn — ADDRESS Lonaconing, Md.

EP
BUREAU V. 9

Within corporate limits Dr. R J Wms ~~DR. BURRETT~~

08093

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08075

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 60 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.
STREET ADDRESS (If rural give location) 1018 ROLLING MILL ALLEY

3. NAME OF DECEASED: (Type or Print) (First) LUCY (Middle) (Last) TYLER

4. DATE OF DEATH: (Month) (Day) (Year) SEPT. 12, 1954 19 54

5. SEX: FEMALE
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: JULY 9, 1911
9. AGE last birthday 43 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): MARYLAND (St. Mary' Co.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: MASON, SAMUEL
14. MOTHER'S MAIDEN NAME: WORRINGTON, MARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, ~~no~~ or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT & ADDRESS: Memorial Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 30 days

ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerosis — 2 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE OF INJURY (Home, farm, factory, street, office bldg., etc
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/14/54, 19 . . , to 9/12/54, 19 . . . , that I last saw the deceased alive on 9/12/54, 19 . . . , and that death occurred at 9:55P.M. from the causes and on the date stated above.

SIGNATURE [signature], M.D. ADDRESS Cumberland DATE SIGNED 9/13/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Sept.17,1954
NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cem.
LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Sept. 16, 1954
REGISTRAR'S SIGNATURE Winter L. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. ADDRESS

M

I

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-5

SEP 21 1954

BUREAU

Within corporate limits: DR. WEISMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08094

08076 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital Memorial Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Milton (Middle) GEORGE (Last) Van Meter

4. DATE OF DEATH: (Month) Sept (Day) 2, (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Dec. 24, 1880
9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer
10B KIND OF BUSINESS OR INDUSTRY: Own Grocery store
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Jacob Van Meter
14. MOTHER'S MAIDEN NAME: Annie Hutson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Memorial Hospital, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Leukemia, acute myelogenous — 4 months

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH General arteriosclerosis — 10 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 29, 1954 to Sept 2, 1954, that I last saw the deceased alive on Sept 2, 1954, and that death occurred at 6:30 P M, from the causes and on the date stated above.

SIGNATURE A Overseman MD — ADDRESS M. D. 59 Greene St Cumberland — DATE SIGNED 9/3/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Sept. 5, 1954
NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Sept. 4, 1954
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: Charles L. George, ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-

Write corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08095 ~~080~~

08077 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-54

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 12 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1020 Ella Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 1020 Ella Ave.

3. NAME OF DECEASED: (Type or Print) (First) Elsie (Middle) V. (Last) Walker

4. DATE OF DEATH. (Month) (Day) (Year) September 24, 54

5. SEX. F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH August 1, 1903

9. AGE last birthday 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (State or foreign country) Licking County, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. H. Andrews

14. MOTHER'S MAIDEN NAME: Mary E. Victor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Oren A. Walker 1020 Ella Ave.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Myocarditis c Decompensation - 6 mon.

(C) Diabetes Mellitus — 7 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947, to Sept. 24, 1954, that I last saw the deceased alive on Sept. 23, 1954, and that death occurred at 9:30 P. M., from the causes and on the date stated above.

SIGNATURE Clay E. Jarrett M. D. ADDRESS Cumberland DATE SIGNED 9/25/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 9-27-54

NAME OF CEMETERY OR CREMATORY Irville Cem.

LOCATION (City, town, or county) (State) Irville, Ohio

DATE REC'D BY LOCAL REGISTRAR Sept. 25, 1954

REGISTRAR'S SIGNATURE Winter R. Frantz, M. D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Maryla

SEP 23
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08096

08100 **CERTIFICATE OF DEATH** Reg. Dist. No. 8

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-

1. PLACE OF DEATH: COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore; MARYLAND LENGTH OF STAY (in this place) 24yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gilmore; STREET ADDRESS (If rural give location) (Rural) Near Midland.

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Duncan (Last) Walker

4. DATE OF DEATH: (Month) Sept, (Day) 13 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH. June, 12 1910

9. AGE last birthday 44 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintainence-Kelly Springfield Tire Co.

10B. KIND OF BUSINESS OR INDUSTRY: Midlothian, Md.

11. BIRTHPLACE (State or foreign country) U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Walker

14. MOTHER'S MAIDEN NAME: Janet Brimlow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-01-8859

17. INFORMANT & ADDRESS: Mrs. Margaret Walker, (Wife) Gilmore, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary Heart Disease — 3 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1952, to Sept 13, 1954 that I last saw the deceased alive on 9-13, 1954, and that death occurred at 11 P M, from the causes and on the date stated above.

SIGNATURE George Richard Jr. M. D. ADDRESS Lonaconing DATE SIGNED 9-13-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept, 16, 1954

NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park.

LOCATION (City, town, or county) Frostburg, Md, (State)

DATE REC'D BY LOCAL REGISTRAR 9-16-54

REGISTRAR'S SIGNATURE Jeanette M. Toal

24. FUNERAL DIRECTOR George Eichhorn, ADDRESS Lonaconding, Md.

KEAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08097

08078 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 148 Frederick Street

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Louis (Last) Walker
4. DATE OF DEATH (Month) 9-2 (Day) (Year) 1954

5. SEX Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH: 8-7-1906
9. AGE last birthday 48 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mech.
10B. KIND OF BUSINESS OR INDUSTRY Own Garage
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert S. Walker
14. MOTHER'S MAIDEN NAME: Grace M. Dermer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-6633
17. INFORMANT & ADDRESS: Mrs. Thelma Walker, Cumberland, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE 571.0 (A) Cirrhosis of Liver
DUE TO
ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1954, to Sept. 2, 1954 that I last saw the deceased alive on Sept. 1, 1954, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Cloyd E. Durrett M.D. M.D.
ADDRESS Cumberland
DATE SIGNED 9/3/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial
DATE THEREOF 9-5-1954
NAME OF CEMETERY OR CREMATORY Lybarger Lutheran Cem.
LOCATION (City, town, or county) Madley, Pa. (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 4, 1954
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-5

08098

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08079 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, rural
STREET ADDRESS (If rural give location) Route #5

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Amber Belle Ware

4. DATE OF DEATH: (Month) (Day) (Year) 9-30-54 3:15 P.M.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct. 2 1902 (1903)
9. AGE last birthday 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lanty Cole
14. MOTHER'S MAIDEN NAME: Lucy C. Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Roy L. Ware, Rt. #5, City

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) apoplectic stroke — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) arteriosclerosis — 10 days

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-19-, 1954, to 9-30-, 1954, that I last saw the deceased alive on 9-30-, 1954, and that death occurred at 4:15 A M, from the causes and on the date stated above.

SIGNATURE L. Rhines M.D. ADDRESS 57 Queen A. DATE SIGNED 9-30-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
DATE THEREOF: Oct. 2, 1954
NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR: Oct. 1, 1954
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: Charles L. George, Cumberland, Md.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-

RECEIVED
OCT 5 1954
SUPREME COURT, U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08099

08080 **CERTIFICATE OF DEATH** Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place) 2 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 132 N. Centre St.

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) (Last) Wentling
4. DATE OF DEATH: (Month) Sept (Day) 20 (Year) 1954.
5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 7-24-'90
9. AGE last birthday 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Radio Service Man.
10B KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Samuel Wentling
14. MOTHER'S MAIDEN NAME: Sarah M. Brunner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16 SOCIAL SECURITY NO. 219-03-9565
17. INFORMANT & ADDRESS: Pt's Chart.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Acute myocardial Failure — 3 days

ANTECEDENT CAUSE (B) DUE TO Myocardial Infarction — 3 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Rheumatic Ht disease — 20 yrs?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Mitral valvulitis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 18, 1954, to Sept 20 1954 that I last saw the deceased alive on Sept 20, 1954, and that death occurred at 12:30 PM, from the causes and on the date stated above.

SIGNATURE Danielle G. Weisman M.D. ADDRESS 59 Greene St Cumberland DATE SIGNED 9/22/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9/22/54
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 22, 1954
REGISTRAR'S SIGNATURE Winter R. Hartz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumb Md

VS. A15—10-

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08100

08081

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Alleg. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.
STREET ADDRESS (If rural give location) 885 Patterson Ave. City

3. NAME OF DECEASED: (Type or Print) (First) Grace (Middle) Susan (Last) Williams

4. DATE OF DEATH: (Month) 9 (Day) 10 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: February 10, 1893
9. AGE last birthday 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Ownhome
11. BIRTHPLACE (State or foreign country): Rawling, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. Lease
14. MOTHER'S MAIDEN NAME: Margaret McKenzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Frank W. Williams 885 Patterson Ave.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSE (S) DUE TO (B) Cerebral arteriosclerosis — 4 months

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) cerebral degeneration

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1, 1954, to 9/10, 1954, that I last saw the deceased alive on 9/10, 1954, and that death occurred at 2:30 PM, from the causes and on the date stated above.

SIGNATURE George M. Symons M. D. ADDRESS Cumberland Md DATE SIGNED 9/11/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9-13-54
NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park
LOCATION (City, town, or county) Cumberland, Md (State)

DATE REC'D BY LOCAL REGISTRAR Sept. 13, 1954
REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR Jas. F. Scarpelli as H. McKay
ADDRESS City

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-

RECEIVED
SEP 21 19[illegible]
BUREAU [illegible]

DR. VAN ORMER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08082 **CERTIFICATE OF DEATH** Reg. Dist. No. 08101 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND — LENGTH OF STAY (in this place) 5 DAYS	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural give location) Church Hill

3. NAME OF DECEASED: (Type or Print) (First) RALPH (Middle) E. (Last) WILSON — 4. DATE OF DEATH: (Month) SEPT. (Day) 8 (Year) 1954

5. SEX: MALE — 6. COLOR OR RACE: WHITE — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED — 8. DATE OF BIRTH: JAN. 24. 1877 — 9. AGE last birthday 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Own Business — 10B. KIND OF BUSINESS OR INDUSTRY: Civil Engineer — 11. BIRTHPLACE (State or foreign country): Wisconsin — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROBERT WILSON — 14. MOTHER'S MAIDEN NAME: MARGARET PENMAN

15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) — 16. SOCIAL SECURITY NO. 214-34-1539 — 17. INFORMANT & ADDRESS: ROBT. D. WILSON LAVALE, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Terminal Heart Failure — 8 days

ANTECEDENT CAUSE (B) DUE TO Myocardial Infarction, acute, anterior — 31 Aug. 54

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Hypertensive Heart Disease — 2 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arterial Hypertension — ?

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Jan. 53, 19....., to 8 Sept., 1954 that I last saw the deceased alive on 8 Sept. 54 19....., and that death occurred at 8:15A M, from the causes and on the date stated above.

SIGNATURE W. A. Van Ormer — ADDRESS M. D. Cumberland, Md. — DATE SIGNED 8 Sept. 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Sept. 10, 54 — NAME OF CEMETERY OR CREMATORY Hill Crest Bur. Park — LOCATION (City, town, or county) Cumberland, (State) Md.

DATE REC'D BY LOCAL REGISTRAR Sept. 10, 1954 — REGISTRAR'S SIGNATURE Walter L. Frantz, M.D. — 24. FUNERAL DIRECTOR Joseph R. Durst, ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-

08101

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08102 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke
LENGTH OF STAY (in this place) 3½ Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Paper Mill

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) Walnut St, Ext.

3. NAME OF DECEASED: (Type or Print) (First) Russell (Middle) Shuey (Last) Wilson, Sr.

4. DATE OF DEATH (Month) Sept (Day) 17 (Year) 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
					Months	Days	Hours	Min.
Male	White	Married	1 June 1896	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Cement Finisher	Paper Mill	Westernport, Md	U.S.

13. FATHER'S NAME: Jacob Wilson

14. MOTHER'S MAIDEN NAME: Mary Ellen Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	215-10-8033	Mrs Elizabeth Wilson, Walnut St. Westernport Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	Immediate
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Arteriosclerosis	
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
		Luke Allegany Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. Acting — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 9/12/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-20-54	Philos Cemetery	Westernport, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-20-54	Mrs Jos C. Kelly	E. S. Boal	Westernport, Md.

RECEIVED
SEP 21 1954
BUREAU V. S.

R/. J. WILLIAMS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08103

08083

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
LENGTH OF STAY (in this place) 6 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 700 GEPHART DRIVE

3. NAME OF DECEASED: (Type or Print) (First) JENNIE (Middle) May (Last) WOLFE

4. DATE OF DEATH: (Month) SEPT. (Day) 28 (Year) 1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) WIDOWED
8. DATE OF BIRTH: AUG. 11 1887
9. AGE last birthday 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Ridgely, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL DIXON
14. MOTHER'S MAIDEN NAME: Emma Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No,
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Mr. Edgar S. Wolfe 700 Gephart Drive Cumb. Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerosis — DUE TO

(C) — DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 10, 1954, to 9/29/54 19....., that I last saw the deceased alive on 9/29/54 19....., and that death occurred at 10:00 A.M. from the causes and on the date stated above.

SIGNATURE R. J. Williams M. D. ADDRESS Cumberland DATE SIGNED 9/29/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10/1/54
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 1, 1954
REGISTRAR'S SIGNATURE Walter K. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

VS. A15—10-

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 5 1954
BUREAU V. S.